DISTRICT OF COLUMBIA

DEPARTMENT OF INSURANCE AND SECURITIES REGULATION

Public Forum

Application of WellPoint Health Networks,Inc.
Regarding Conversion and Acquisition of Control of
Group Hospitalization and Medical Services, Inc.

Wednesday, May 22, 2002

6:03 p.m.

441 4th Street, N.W.
Auditorium
Washington, D.C. 20001

P R O C E E D I N G S

COMMISSIONER MIREL: I would like to start as close to the starting time as I can because we want to make sure everybody gets a chance to testify.

Good evening. I am Larry Mirel, Commissioner of Insurance and Securities Regulation for the District of Columbia. Tonight we are conducting the first of two scheduled public forums to hear from the public on the proposal by WellPoint Health Networks, Inc., a California-based health insurer, to purchase CareFirst, a Maryland-based health insurer.

CareFirst is the parent corporation of Group Hospitalization and Medical Services, Inc., GHMSI, the District's Blue Cross-Blue Shield health plan. CareFirst also controls Blue Cross operations in Maryland and Delaware. CareFirst is a nonprofit corporation. WellPoint is a for-profit corporation.

Part of the proposed transaction would require that CareFirst be converted to a for-profit

entity so that WellPoint can purchase its stock. The value of CareFirst, as reflected in the sale of its stock to WellPoint, would be put into a trust for the benefit of the people of the affected jurisdictions. WellPoint's proposed purchase price for CareFirst is $1.3 billion.

Looking at the table tonight, our Leslie Johnson, the hearing officer for the Department of Insurance and Securities Regulation, who will assist me with the procedural aspects of this process, and Ark Monroe, an attorney with a Little Rock, Arkansas law firm of Mitchell, Williams, Selig, Gates & Woodyard, which has substantial experience with the conversion and sale of Blue Cross entities. Mitchell, Williams has been retained by DISR to provide legal advice on this complex proposed transaction.

Let me begin by describing the process we will follow. For the proposed transaction to go forward, it needs the approval of the insurance commissioners of the three affected jurisdictions; the District of Columbia, Maryland and Delaware.

Before I can approve the transaction on behalf of the District of Columbia, I must be assured by the D.C. Corporation Counsel that the District's share of the proceeds of the sale is adequate and that the funds are properly protected for the benefit of the public.

The Attorneys General of Maryland and Delaware have similar functions to perform under their State laws.

Finally, because GHMSI, the District's Blue Cross-Blue Shield program, is chartered as a nonprofit corporation by Congress, congressional approval is also needed.

Tonight we are beginning the review process by asking for public comments. We will continue that part of the process with the second public forum to be held in this room next Tuesday, May 28th, from 6:00 to 9:00 p.m. If necessary, we will hold additional forums at dates and times to be announced.

We will also be hiring experts to analyze the documents WellPoint has put forward in support

of the proposed transaction, including a financial expert.

The Office of Corporation Counsel will separately retain an investment banking firm to value CareFirst and GHMSI and assist in the establishment of a charitable foundation if the transaction is approved.

Finally, a formal hearing will be held sometime in the fall of this year at which WellPoint will present its proposal and opposing parties will have an opportunity to present evidence and witnesses in opposition, as well as cross-examine WellPoint's witnesses.

After reviewing the entire record, and receiving a decision from the Corporation Counsel as to the value of the transaction, and protection of the assets for the public, I will render my decision whether to approve or disapprove the proposed transaction.

The standards governing the determination I must make as commissioner are set out in two District of Columbia statutes. The first deals

with the issue of whether CareFirst, GHMSI should be allowed to convert from nonprofit to for-profit. That law says that the conversion shall be approved unless I find that the plan, one, is inequitable to contract holders of the converting corporation or the public; two, fails to comply with certain procedural requirements; three, provides that any part of the assets or surplus of the corporation will inure directly or indirectly to any of its officers, directors or trustees; or, four, does not ensure that WellPoint as the resulting stock insurance company will possess capital and surplus in an amount sufficient to comply with capital and surplus requirements for a stock life company under applicable law and provide for the security of WellPoint's contract holders.

By the way, copies of this statement are available over there, so if you can't follow all of this, please feel free to pick them up.

The second law is concerned with the standards for determining whether the acquisition of control of the District's Blue Cross-Blue Shield

program, GHMSI, by WellPoint should be approved.

The statute says that the transfer of control shall be approved unless, after a public hearing, I find that, one, after change of control the plan would not be able to satisfy the requirements for the issuance of a license to write accident and health insurance in D.C.; two, the effect of the acquisition of control would be to substantially lessen competition in insurance in D.C. or create a monopoly; three, the financial condition of WellPoint is such as might jeopardize the financial stability of GHMSI or prejudice the interests of its policyholders; four, WellPoint's plans or proposals, if any, to make material changes in the operations, structure or management of GHMSI, are unfair and unreasonable to policyholders of GHMSI and not in the public interest; five, the competence, experience, and integrity of management who would control the operation of GHMSI, are such that it would not be in the interest of GHMSI's policyholders and of the public to permit the acquisition of control; or

finally, six, the acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

At the formal hearing in the fall, there will be two ways to participate. If you simply have a view that you wish to express, you will be afforded an opportunity to submit written comments. If you are interested in participating as a formal party you must file a written motion to intervene which identifies the nature of your interest in the proceeding, states how the outcome of the proceeding will affect you, and describes any other factors that would warrant your participation as a party.

Any party who is allowed to participate as a party, any person who is allowed to participate as a party, will be allowed to conduct discovery, offer evidence, examine witnesses, and file written briefs.

Participation as a party will also carry with it significant responsibilities. Every person who participates as a party will be obliged to

respond fully to discovery requests served by the other parties. The witnesses offered by a party will have to be made available for cross-examination by all other parties. Every party will

be expected to attend all hearings and status conferences, to file briefs and pleadings, and to provide all other parties with formal service of all filings they make.

The obligations are serious and should not

be undertaken lightly. If you are interested in participating as a party, I encourage you to review the case management order to make sure you understand all of the relevant deadlines, opportunities and obligations involved in

participating in these proceedings.

The process of reviewing WellPoint's application is open to the public. All of the pleadings filed with the department and all of the orders entered in this proceeding will be available

for review at DISR. If you are online, all of the pleadings and orders are also available on the website that the department has established for

this matter, www.DISRwashingtondc.gov.

The WellPoint proposal was filed with our department on January 11th, 2002. On April 5th, 2002, I issued a preliminary order finding that the application was deficient in that it lacked sufficient detail to enable the commissioner to make a thorough review and a reasoned decision.

The applicants were directed to file a draft amended and restated application on or before July 16th, 2002, to remedy the deficiencies. A letter specifying what further information is needed was sent to WellPoint yesterday. Copies of that letter are available to the public and are over on the table there.

The reason we requested that the amended application be filed in draft form is that D.C. law requires that we render a decision within 30 days after a final application has been filed. We do not believe that 30 days will give the public or our experts enough time to properly evaluate the amended application. We have asked that the final application not be filed until October so that the

clock for making a final decision will run from that date.

If the final application filed in October differs significantly from the draft submitted in July, accommodations will be made to allow an opportunity for all parties to review the document and be adequately prepared for the hearing.

I want to thank you all for coming here tonight. This is obviously an important decision for our community, and I want to proceed with full opportunity for the public to be heard. The forum is scheduled for three hours, and we have numerous witnesses on the list. Therefore, I will ask that ask witness limit his or her statement to not more than 10 minutes, and we will time that.

We will also accept written comments so that if you did not sign up to testify in person or if your testimony has not been completed in the allotted time, please give us the benefit of your full comments in written form.

Although we have a roster of witnesses, if we have completed the testimony before 9 o'clock, I

will call upon any other person waiting to speak. If you did not sign up for tonight, and we do not get to you before 9 o'clock, you are welcome to sign up for next Tuesday's forum.

A full transcript of this hearing will be made so that I have a complete record before me when I make my decision. Therefore, when you are called upon to speak, please state your name, spell your last name, and if you are speaking on behalf of an organization, give the name of the organization.

Mr. David Wolf of CareFirst is here to make a presentation this evening, and I will ask him to speak first. The 10-minute rule will apply. Mr. Wolf.

STATEMENT OF DAVID WOLF

MR. WOLF: Thank you, Commissioner Mirel. I am David Wolf, W-o-l-f, executive vice president of CareFirst Blue Cross-Blue Shield. I appreciate the opportunity to talk to you about CareFirst's proposed for-profit conversion and merger with WellPoint. The main purpose for the gathering here

this evening is to allow the public to comment on this proposal and for us to listen. We welcome their interest.

Much has already been said and written about our proposal. Many are fearful about what the conversion and the merger might mean for health care in the Nation's capital area for their own personal health care coverage. We understand that it is our responsibility to demonstrate to you why this proposal is in their best interest.

As the commissioner noted, I will spend a few minutes summarizing our proposal transaction.

The Blues have served the District of Columbia since 1934. CareFirst is an affiliation of Blue Cross and Blue shield plan serving the District, Maryland, Delaware and even northern Virginia. We have nearly 3.2 million members, including about 1 million in the District of Columbia. We employ roughly 6400 associates, including 1500 in the District.

WellPoint also is principally a Blues company and is a for-profit company with nearly 13

million members that operates Blues' plans in California, Georgia and Missouri. WellPoint has been named the best large health company and most admired health care company by national publications. We are confident that we have selected a partner that shares our commitment to providing quality care.

CareFirst has filed applications in Maryland, Delaware and the District seeking permission to convert from our current not-for-profit status to become a for-profit company upon which CareFirst would be acquired for $1.3 billion by WellPoint. Our proposal requires approvals from the regulators in the three jurisdictions. Also the Blues plan being federally-chartered, we will need approval from the U.S. Congress.

There is a thorough review process of which today's public forum is a part. We would expect to take about 12 more months.

We believe there is much to tell you about the benefits of the transaction, but none more so than the agreement's potential benefit to do good.

The District of Columbia, Maryland and Delaware will share the $1.3 billion to be paid as charitable trusts which we hope will be used to address the unmet health care needs in each of the jurisdictions. The interest earned from each jurisdiction's share of the proceeds, when coupled with the health care dollars from the community, could have a substantial impact on providing for currently unmet health care needs. These items can include such things as funding for open enrollment products, for those who have preexisting medical conditions who are currently uninsurable, providing prescription drugs to the elderly, providing community health clinics to the District's low-income residents, and more.

Some other things you might be interested in is that after the transaction's completion, we would continue to be regulated locally by the District Department of Insurance and Securities Regulation. CareFirst would continue to have a strong local presence. Our agreement with WellPoint explicitly preserves our operating

headquarters in Maryland, Delaware and D.C. Health care decisions affecting our members' coverage will continue to be made locally.

We are committed to sustaining our local employment. That is significant because CareFirst is an important part of the economic health of the D.C. community. We have recently demonstrated our long-term commitment to the District. Last year we entered into a 10-year lease for the Portals Building on Maryland Avenue, Southwest for our 845 associates serving the Federal employees' program. And just last month we announced a 10-year lease for a brand new building on First Street, Northeast, for another 1100 D.C. associates.

As a result of this transaction, several new benefits can be available to our members. Our customers will have access to new products and services providing members with increased flexibility and additional choices regarding deductibles and copayments. Innovative disease management programs, pharmacy discount programs, expanded alternative medicine offerings, and

products for those currently without health insurance.

As a matter of fact, WellPoint's testimony in the Maryland hearings indicated that they identified the uninsured as a potential growth opportunity and have made extensive efforts to reach out to this population.

We will have resources to invest in needed technology that will allow us to answer member calls more quickly and accurately, improving our ability to get things done the first time. We will be able to improve our online capabilities with such 24/7 enrollment, claims tracking, physician selection, name changes; things that will make it easier to manage your health care.

By combining with WellPoint, we expect to take advantage of the administrative efficiencies that will slow the rate of premium increases. Medical inflation isn't going away, but by increasing our efficiency through the application of technology and better applying technology to assist in getting members the care that they need,

we can limit administrative costs and reduce the cost of care.

Again, at the Maryland hearings, the WellPoint chairman, Leonard Schaefer, testified that the premiums will not increase as a result of this conversion or acquisition.

We also see this transaction as a growth opportunity. The metropolitan D.C. area represents a significant source of membership growth for CareFirst. With new products and better service, we expect that this area will provide our company with the growth that it needs to remain competitive.

We are also confident that the agreement will help us to work better with our health care partners, physicians, hospitals and others. By investing in technology, it will help us to process and pay claims faster and improve our ability to verify and review the results of claims in real time.

The structure of the agreement ensures that the relationships with and the decisions that

affect providers will be made, as they are now, locally. And local regulatory oversight of CareFirst, which is understandably important to health care providers and elected officials, will continue and will be unaffected by this merger.

Benefit to the communities in which we operate will be the greatest outcome of this transaction, and there will be significant dollars which will flow into the District, Maryland and Delaware to address the unmet needs. Think about this. The mayor has had to cut nearly $12 million this year alone from the Health Care Safety Net Administrative, funding that could have been used to address the care for the District's low-income and uninsured residents. Imagine what D.C. could have done with its share of the $1.3 billion.

We will be more specific about the potential uses of these funds in the filings as part of the amendments in July, as has been requested by your staff.

The bottom line is GHMSI, your Blue Cross and Blue shield plan in the District, is still

going to be there for its residents, customers and the community, and we believe it will even be better, with more products, better services, a new southeast regional headquarters, and a share of $1.3 billion. We truly believe that this can be a win-win for all constituents.

Thank you, Commissioner.

COMMISSIONER MIREL: Thank you, Mr. Wolf. Thank you for sticking within the time limit.

Our next witness is Sharon Baskerville.

STATEMENT OF SHARON BASKERVILLE

MS. BASKERVILLE: Good evening. I am Sharon Baskerville, B-a-s-k-e-r-v-i-l-l-e. I am the executive director of the District of Columbia Primary Care Association, and I am pleased to have the opportunity to testify today about the proposed CareFirst conversion to for-profit in the subsequent sale to WellPoint.

DCPCA is a nonprofit membership organization that actively works to facilitate health care reform in the District, with the focus on primary and preventive care. Our membership

includes representatives from the health care community clinics, hospitals, government and health care advocacy groups. In our capacity as a facilitator for broad-based systemic health reform, DCPCA works to develop and implement solutions to the many problems in the health care delivery system that must be addressed if we are to reverse the District's terrible health outcomes.

Through our collaborative efforts, we work to find solutions that will both benefit the medically vulnerable and meet the fiscal needs of the District.

DCPCA is also a member of the CareFirst Watch Coalition, and I serve on the steering committee, and while DCPCA has not taken an official position on the merger, we have listened to and weighed the arguments from both sides, and many questions remain unanswered.

We know the history. CareFirst owns the Blue Cross-Blue Shield plans covering the District, Maryland, Northern Virginia, and Delaware. Its mission is to provide affordable insurance to

people who have difficulty obtaining coverage and be dedicated to community health outcomes and concerns.

We know that in January 2002 CareFirst Blue Shield application to become for-profit and sell itself for $1.3 billion to WellPoint Health Networks of California, a national for-profit health insurance provider. If the deal is approved, WellPoint will gain an additional 3.1 million members and become one of the largest health insurers in the country.

DCPCA has strong reservations about this deal. It is troubling to us that the only group supporting the merger are the two parties to the deal, CareFirst and WellPoint. Physicians, medical societies, hospitals and health care advocates all seem to oppose. No other group has come out in support of the merger, and the question is why not?

The answer to that question probably lies with the fact that there are so many unanswered questions. In particular, what is at stake? How does this merger benefit District residents, and

will there be any harm to District residents?

I want to address first what is at stake, and I want to focus on protecting the health care system net because of utmost concern to DCPCA is protecting the health care safety net.

The most critical challenge for the city's health care system lies in the delivery of health care services to the medically needy, the uninsured and underinsured. However, the District's health care safety net system is inadequate, fragile, and currently undergoing major transition. Historically the safety net system included the public system, the now-defunct Public Benefit Corporation, the hospitals and the nonprofit clinics. For years many of the historical safety net providers have operated without adequate facilities and lacking the management information and practice management systems needed and deserved by the medically vulnerable. Revenue, primarily from philanthropy, was devoted to direct patient services, with little available for bricks and mortar improvements, or infrastructure building.

The District has done little until recently to invest in improving the safety net. Last year the District transitioned from a public system to a private contractor, Greater Southeast Community Hospital to provide health care for the uninsured. It was a conversion of sorts that rocked the city, and we all lived through that, and it was very painful.

The PBC included D.C. General Hospital and primary care clinics. That no longer exists by order of the financial authority. Instead, the D.C. Health Care Alliance has replaced the PBC. D.C. General now provides only emergent, urgent and specialty care. No one knows whether the new health care delivery system will work or not, whether this is the solution to caring for the uninsured. The program is in untested waters, and there really is no other similar health care system in the United States that we can compare it to, so we don't know what the future holds for the alliance.

The public health served 33,000 uninsured

persons, regardless of ability to pay. The private system now has 28,000 members, with an eligibility requirement of being under 200 percent of the Federal poverty level. That requirement excludes many persons that are above the 200 percent poverty level. For an example, a family of one, maximum income is $17,000; family of two, maximum income of $23,000. Many of these persons are the working poor, persons who work for small employers who do not offer health insurance. The nonprofit clinics, which see persons regardless of ability to pay, continue to serve the remaining 66,000, or two-thirds of the uninsured, many from the District's immigrant community.

As a member of the Mayor's Health Services Reform Commission that oversees the alliance contract, I am painfully aware of the fragility of the new-found health care program. After one year of operation, the mayor's proposed budget cuts would have greatly impacted the program, but the D.C. Council fought and restored funding. We still have a $5 million deficit, however.

Given its financial picture, there is a real possibility that some of the providers will pull out if they are not properly reimbursed for their services.

Thus, the stability of the health care safety net is a major concern. We are concerned about any action or decision that has the potential to further destabilize an already fragile safety net. Should the worst-case scenario happen and an increase in the number of uninsured result, that would be tragic because there would be a heavy burden on the safety net, and the nonprofit clinics that are dependent financially upon foundation support are already struggling to provide services for many patients with few resources.

Hospitals already experiencing high emergency room use by those without insurance will be further burdened. The alliance's funding is not sufficient to care for all the uninsured and will certainly not be able to pick up the slack of a number of uninsured increases.

There is no longer a public health care

system. We need to make sure this deal does not leave the District scrambling for ways to cover the uninsured who were previously CareFirst members.

There is an article today in The Washington Post that reports on the consequences of being uninsured entitled "Study: Uninsured Don't Get Needed Health Care; Delayed Diagnoses, Premature Death Results."

The article reports that the lack of health insurance leads to delayed diagnoses, life-threatening complications and premature death because being uninsured causes many to belatedly discover and seek treatment. That translates into premature death for a city that leads the Nation with these diseases, and further speaks to the dire need to avoid any actions or deals that have the potential to increase the number of uninsured in the District.

Do we really need another public benefit foundation? The merger will profit the public benefit foundation that will be established to administer the public assets the District will

receive, will make the safety net stronger? We have little confidence that a public benefit foundation will be the answer. Can a foundation adequately replace CareFirst? Would a charitable health foundation work for the District? Will the foundation improve the health of the community? The District's track record with the PBC, which was underfunded and poorly managed and lasted only six years, gives us little assurance.

How will the foundation operate in the out years after the initial infusion of cash from the merger and will it require local funding are questions that need to be answered.

Will the sale cause people to lose their insurance? Given the District's fragile safety net system, the recent tragic events of September 11th, the resultant economic uncertainty, what will the health impact of the merger be for the most vulnerable in the District, the uninsured?

With high numbers of uninsured and a safety net in transition, we cannot afford the possibility of a shrinking insurance market.

Again, who will pick up the burden of caring for the uninsured if the merger fails?

DCPCA believes that a nonprofit health care insurer operating in accordance with its charitable mission better serves the public. As a nonprofit, CareFirst has received tax exemptions in exchange for its open enrollment of people who are considered high risk and not otherwise insurable. This means it is essentially an asset of the community at large. If Commissioner Mirel and Corporation Counsel Robert Rigsby approve the merger, this tax-free status will be eliminated. When a nonprofit converts to for-profit, it is supposed to turn its current economic value over to the State so the original charitable mission can continue. We must have assurances that CareFirst won't abandon its mission. We must have assurances that the uninsured will be cared for if the sale of CareFirst goes through. The sale must not cause people to lose their insurance coverage.

In my testimony, which is submitted in its entirety--I'm going to skip around a little bit in

the interest of time--I'm concerned especially--

COMMISSIONER MIREL: You have one more minute.

MS. BASKERVILLE: That's fine.

--about the $1.3 billion price. We believe the valuation is probably way too low, and we have presented our arguments along with what the requirements of a conversion are in the city. We discuss how the merger benefit will affect District residents, and in summary, I essentially want to say the proposed conversion of CareFirst to for-profit and the sale to WellPoint will be one of the most significant transactions ever for the District. My testimony is full of questions that need to have answers and hopefully will be answered before the deal is done, before the District moves too quickly on approving the conversion. There are options the decision-makers may want to consider, and we have outlined those.

Without convincing, compelling, and well-documented answers to the myriad of questions and concerns, I anticipate my organization will join

others in officially contesting the conversion. We will also watch and monitor with great interest our government leaders in this debate, as we expect their aggressive protection of the citizenry of the District of Columbia.

I thank you for the opportunity to present this testimony.

COMMISSIONER MIREL: Thank you very much for your testimony and for sticking to the time limit.

The next witness is Mr. Sam Jordan.

STATEMENT OF SAM JORDAN

MR. JORDAN: Thank you, and good evening. I am Sam Jordan, director of Health Care Now, a project of the Center for Community Change. Health Care Now opposes the conversion of CareFirst Blue Cross-Blue Shield to a full profit status and a subsequent acquisition or merger with WellPoint Health Networks of California.

We object to the proposed conversion and merger because we have seen nothing in the proposal that promotes the public interest. Instead, it

appears that the proposal benefits in the main, if not solely, the proponents of the transaction, WellPoint and CareFirst executives, and WellPoint shareholders.

A growing number of CareFirst subscribers have begun voicing their opposition to the proposal as well. I am also a CareFirst subscriber.

The short list of our anxieties surrounding this proposal would include, A, the fear of increased numbers of uninsured, due to increased premiums; B, the closure of open enrollment; C, loss of coverage for the less profitable lines of insurance, including persons with prior existing conditions, chronic illnesses, small employer plans, the self-insured or individual policyholders; and D, the added burden on the public health care services system.

Studies of conversions around the country conducted by a number of health industry analysts and other independent entities, including Community Catalysts of Boston and the Maryland Hospital Association, MHA, have concluded that conversions

in other States have not had a positive impact for the public or providers.

A survey conducted by MHA and its CareFirst conversion task force in the summer of 2001 found that "none of the plans improved their behavior in any area of public accountability, subscriber service or provider relations."

In the case of Blue Cross of California and WellPoint, help with uninsured flexibility, help with uninsured, flexibility in providing coverage and service to subscribers stayed about the same, while their behavior worsened in terms of responsiveness to State policy regulation and legislation. Levels of denials issued, level of payments to providers, handling of disputed claims and contract negotiations with providers.

Health Care Now believes that due to the control that WellPoint will exercise over CareFirst, it is highly probable that the conversion would likewise have a negative impact on several areas of its public accountability, subscriber service and provider relations in

Maryland, the District and Delaware.

When we reviewed conversions in other States, instructive examples emerged. In North Carolina, a conversion bill passed in 1998, the bill permits Blue Cross-Blue Shield to effect a complete conversion that will have occurred by presumption when for-profit activity exceeds 40 percent of its business. This has been interpreted by critics of the legislation as permitting BSBC of North Carolina -- BCBS, rather -- to be fattened substantially to make itself more attractive for acquisition.

According to recent studies regarding the proposed CareFirst conversion, CareFirst has increasingly assumed the character of a for-profit insurer but without the legislative permissions.

There is concern that CareFirst has abandoned its original charitable purposes and public service values. The concerns suggest to Health Care Now that CareFirst has taken a path that has seen its value appreciate in the regional and national insurance, not to maintain its

original charitable mission, but to attract a deep-pockets merger partner.

CareFirst's abandonment of the Delmarva and Freestate plans and several Medicaid programs have been cited by the Maryland legislature in its insistence that CareFirst remember its origins and the source of much of its market value and favorable market positioning.

What would normally be an occasion to applaud the work of a dedicated, competent management has become instead an occasion to question the motives of CareFirst's senior executives. These questions must become the subjects of intense examination and analysis by the Office of the Commissioner, the Corporation Counsel and the District's elected officials. We have as yet received no explanation for the $1.3 billion sale price negotiated by CareFirst and WellPoint.

When Virginia's Trigon announced its agreement to be acquired by Anthem at a higher price than CareFirst, while serving fewer subscribers, CareFirst-WellPoint offered a

mumbling, half-intelligible claim that we can't compare the transactions. But they no longer boasted that their proposal was the best thing to happen in the regional insurance market.

Have CareFirst and WellPoint purposely lowballed the sale price in order to fatten the compensation envelopes of executives and to show an initial burst of profitability to Wall Street? Health Care Now believes we have been set up for a scam by CareFirst-WellPoint.

Where is the proof that the sale price, $1.3 billion, has taken into account the decades of public support? Where is the proof that the sale price represents anything close to market value of the company, relying heavily on certain of its product lines on Federal and local governmental employers? An almost recession-proof source of dependable profits.

Why has the Maryland legislature's requirement of an all-cash transaction created such havoc and second-guessing lately by WellPoint? Is it because the cash portion of the offer, $450

million, when subtracted from CareFirst's cash reserves of approximately $700 million, would leave just enough for CareFirst to meet the legal requirements for reserves set by the legislature?

This is the Icahn-Buffett theory of acquisition and practice. Let the acquired company pay for the transaction out of its reserves or unprotected pension plan.

You are aware, Mr. Commissioner, although many of today's witnesses have not been apprised, that in April CareFirst asked the Delaware Commissioner to suspend any further examination of its application for conversion and merger. The company did not send the same letter to you or to Mr. Larsen, the Maryland Insurance Commissioner. CareFirst was reacting to the action taken by the Maryland legislature.

In addition to the all-cash requirement, the legislature forbade the $3 million in bonus payments to executives should the conversion merger be approved. This is, after all, money that the State helped CareFirst to earn without a bonus to

the public.

The legislature also required CareFirst-WellPoint to assume the burden of proof in demonstrating that the proposal was in the public interest.

There have been reports that you, Mr. Commissioner, have described the Maryland legislative acts as onerous. Immediately following the formal submission of CareFirst's proposal in January, you were reported to have said that you "saw no reason why this transaction should not go forward," or words to that effect.

Health Care Now, as part of the CareFirst Watch Coalition, has been an advocate for strengthening the power and resources of your office in order that you might be particularly protective of the interests of the public and subscribers. Nevertheless, we insist that you formally disclose any grounds for bias or history of dealing with CareFirst, WellPoint, the Blues plans and/or other industry entities that might weigh upon your decision-making objectivity in this

matter.

We raise these concerns here and publicly, Mr. Commissioner, because in those cases where objectivity dominates the conversion application process, the public and subscribers will be served best.

In Kansas, the insistence on due diligence and examination of the impact on the public interest led the insurance commissioner to reject the proposed conversion and merger. The rejection occurred even after Blue Cross-Blue Shield of Kansas had established a foundation, the $75 million Sunflower Foundation. There are, of course, differences in the Kansas market and the nature of a demutualization when compared to this region's insurance market and the nature of the instant proposed conversion and merger. The principle remains the same, however: We don't need bias.

When an insurance commissioner, like Commissioner Sibelius in Kansas, disregards the high-powered lawyers and threats of suits,

disregards the vaunted lobbying clout of the proponents, even disregards old friendships established through a history of involvement in the insurance industry, and is guided only by the best interests of the public, the real insurer of last resort, when thousands lose coverage because of a conversion, only then will Health Care Now be confident that we might have the fairness contemplated by the law.

Health Care Now will continue to support appropriate strengthening of the authority vested in your office in order that the decision in this case might comport with our search for affordable, high-quality, accessible health care services, with fairness for all health care consumers.

We would not close our remarks without reference to reports in the major media outlets that we are to expect significant increases in the cost of insurance premiums. Some estimates range from 15 to 25 percent in the next year alone. Today's USA Today carried a front-page article giving estimate to the number of deaths caused by a

lack of insurance coverage. That number, 18,000, is chilling. Eighteen thousand per year.

The majority of these deaths were preventable. Yet conversions are everywhere accompanied by increases in premium costs. Are we anticipating premium increases in this market due to market forces, augmented by additional increases due to the need for profit creation promised by CareFirst on reports prepared by Accenture?

Perhaps CareFirst-WellPoint should be required to indicate how many will lose their coverage due to the conversion and, of those, how many may die. Is this a little too dramatic? Just ask the clinics and hospitals that are already serving the uninsured. They will tell you just how many clients suffer health conditions aggravated by waiting and procrastination due to the lack of insurance coverage.

COMMISSIONER MIREL: Mr. Jordan, we are coming up on one minute.

MR. JORDAN: Thank you.

Let me quote a passage from the USA Today

article.

"About 25 percent of adult diabetics without insurance for a year or more went without a checkup for two years. That boosts their risk of death, blindness and amputations resulting from poor circulation."

I draw your attention to that passage because of a little-known fact about Washington, D.C.'s health indicators. In the last year of operation of D.C. General, the true insurer of last resort, the single most common cause of death was due to infection and sepsis caused by diabetes. Yet nowhere in the CareFirst-WellPoint application has concern been shown about the fate of those who will lose coverage, those who will not be able to find alternative insurers, those who will add to the overwhelming burden of clinics and emergency rooms. Without such a reference, can CareFirst-WellPoint be said to have concerned themselves with the consequences of their search for profits at the public's expense? Without reference to consequences, can CareFirst-WellPoint be said to

know the fair price of conversion?

A coauthor of the report cited by USA Today is our former chief health officer, Dr. Reed Tuckson. We have trusted him in the past.

Finally, for Health Care Now and many others who oppose the conversion and merger, this question has not been answered. Why does CareFirst need to convert and merge? This conversion makes sense only to Wall Street and profiteers.

We recommend rejection of the proposed conversion and merger and that CareFirst return to its original purposes. And thank you.

COMMISSIONER MIREL: Thank you, Mr. Jordan. We will read all of your statement, including the part that you didn't get a chance to give tonight. Thank you very much.

The next witness is Dr. Judy Okkema. Did I pronounce that correctly? Is she here? If not, I will go to the next witness, Michael J. Arens. Is he here? Mr. Arens.

STATEMENT OF MICHAEL J. ARENS

MR. ARENS: Thank you, Commissioner Mirel.

My name is Mike Arens, spelled A-r-e-n-s. I am a CareFirst Blue Cross-Blue Shield associate.

I appreciate the opportunity to speak to you tonight and give you some comments from the perspective of a CareFirst associate.

I have worked at CareFirst for over 30 years. I currently work in information technology, and I have -- I work at both the Owings Mills, Maryland and the Washington, D.C. offices. I have worked at Blue Cross during good times and bad times in those 30 years. I was here 10 years ago when the company was nearly bankrupt, when our customer service scores were at the bottom of all Blue Cross-Blue shield plans and we had massive lay-offs. And I have been here also when things got better, and when associates can now be proud of the company for which they work.

Let me say that associates trust Mr. Jews, our president, as the leader of this company.

When Maryland and D.C. plans affiliated, four years ago, a lot of D.C. associates were afraid they would lose their jobs. Mr. Jews made

it a priority to communicate to the associates both the direction and the current status of the company. And they did it regularly.

One of the messages was that jobs and job opportunities would grow as membership grew. In fact, that is what has happened. We have learned through this experience and others like it that Mr. Jews is a man of his word and that he does in fact have a vision for this company.

CareFirst associates are fully supportive and excited about the proposed conversion and merger because we feel that it will allow our organization to continue to provide quality health care and grow.

The company has done a lot to communicate to associates everything possible about this proposed conversion and merger. I can't pretend to be an expert, but I can say that I am proud of what we have accomplished in the past, and I trust that this is an opportunity for us to grow and to take an important next step as a company.

Today I would like to speak again from the

perspective of a person who has been in information technology for over 30 years at CareFirst. With that perspective in mind, I would like to suggest why I think the proposed conversion and merger is an important next step.

We have said that by converting to a for-profit status, the transaction will provide access to capital to invest in information systems. Information technology expenses are a large component of the overall cost of doing business in any organization, and particularly for CareFirst. It takes a great deal of new dollars every year, for example, to meet costly mandates like the Health Information Portability and Accountability Act, HIPAA, to create more contemporary ways for our customers and providers to conduct business with CareFirst and to make our systems more efficient.

I would like to elaborate on why I think merging with WellPoint would help information technology and thus help CareFirst to be more efficient. I hope to show that the less money we

spend on duplicative technology, the more we are able to keep health insurance premiums stable. Here is what I mean by that.

Back in the 1930s, when Blue Cross-Blue shield plans were first founded, there were no computers. Gradually that changed. We applied computer automation to such functions as claims processing, billing and enrollment. However, because they were operated independently, each insurance company, Blue Cross and Blue Shield plans included, approached the development of these systems as a unique business problem.

The consequence was that among insurance companies, millions of dollars have been spent and continue to be spent on duplicative software and hardware in systems such as claims and enrollment, as well as systems that are purchased from IT software vendors.

Since January of 1998, when the D.C.-based plan and the Maryland-based plan merged, we in IT have been engaged in a process of eliminating that duplication. We have proven that significant

dollars can be saved by eliminating.

Mergers of Blue Cross-Blue Shield plans are one of the clear ways to ensure that IT dollars go further. As merged plans, there is strong incentive to do that. It has been my experience as a result of the merger of the D.C. and Maryland-based plans the consumer wins because dollars saved through consolidation of systems reduces the overhead of operating a company and can be used to keep costs and therefore premiums down.

As an associate, I have been disappointed by some of the unwarranted attacks that have been made on my company and its leadership. I can only assume that opponents' criticism is based on fear and a lack of understanding about what we are proposing to do.

I hope that I have helped illustrate one of the things that we are proposing to do. We think that if people are given the chance to hear the reasons for CareFirst's decision and the potential benefits, they will understand why it makes more sense. All we can ask is that CareFirst

be given the opportunity to be heard, and I thank you.

COMMISSIONER MIREL: Thank you very much, Mr. Arens.

The next witness is Marcio Duffles. Is he here? Okay. Well, your timing is excellent.

Mr. Duffles, since you weren't here before, we have a 10-minute rule. So please go forward. We will let you know when there is a minute left.

STATEMENT OF MARCIO DUFFLES

MR. DUFFLES: Very good. Thank you.

Good evening. My name is Marcio Duffles. I am an aerospace engineer and the president of America's Phoenix, Incorporated. It's an aerospace consulting firm serving clients throughout the Americas.

But tonight I am here to speak as the founding director of Summertime and Reading Together, or START, Incorporated. We are a 501(c)(3) children's summer literacy program in the Washington metro area, serving children between the

ages of 5 and 14.

I want to focus on two things. One is how CareFirst has contributed to START's mission of offering children the opportunity to advance their lives through literacy; and two, the further benefits that can be achieved if the proposed sale of CareFirst is approved.

My first point concerns a reading program I began in 1988 by reading with six children in my Capital Hill neighborhood. I am proud to say that today START supports 12 neighborhood-led book clubs, with over 400 children participants in the D.C. area. Ours is a grassroots organization. We are dependent on volunteer readers whom we train and match with children to read individually during the summer months, and to participate in group reading activities with the neighborhood book clubs.

START provides the children with new and used books, book report booklets, funds educational literacy-based field trips, and conducts an annual fall awards dinner to acknowledge START's top

readers and volunteers for their efforts. START provides this support to neighborhood-led book clubs free of charge. In order to provide this free service to the neighborhood book clubs and their children, START relies solely on the generous contribution of individuals and corporations. With last year's recession and the events of 9/11, 2001 was a particularly difficult fund-raising year. START received less than half of its normal corporate sponsorship of its main fund-raising event, the Pennsylvania Avenue Mile Booking for Literacy Race.

However, CareFirst committed to START as a major sponsor early last year and kept its promise. CareFirst's generous contribution of $20,000 over the past two years has allowed START to further expand its reach into Washington's neighborhoods. START's 14th summer of reading with Washington's children will support an additional two new neighborhood book clubs and allow START to continuously improve the quality of its program.

I have personally observed CareFirst's

generosity as a corporate citizen in our community. I have observed the lifelong benefits that a summer of reading with caring adults has provided to children in our community. The testimonials are many, but one that stands out is of a young girl, Ms. Candace Johnson, who in 1988 wrote reports on 10 books she read over the summer and took that momentum to raise her grades from C's and D's to become an honor roll student throughout her secondary education. Ms. Johnson recently graduated with a double major in computer science and education from Compton State College.

It is through education and its basic linchpin of literacy that allows boys and girls to become responsible young men and women that care and contribute to their community. Research indicates that functionally illiterate individuals commit 80 percent of violent crimes. I would strongly suspect that similar correlations can be made that relate illiteracy to poor mental health, contraction of sexually transmitted diseases, teenage pregnancies and other health problems.

CareFirst has not only recognized this correlation, but their support of START shows their commitment to eradicate this link between illiteracy and an unhealthy society.

My second point is that, as I understand the proposal, the sale of CareFirst would realize $1.3 billion from Maryland, Delaware and the District of Columbia. This money would be disbursed among the jurisdictions and used in each

to establish a charitable trust to meet local health care-related needs. I understand that the District could expect to receive at least $400 million.

Charitable organizations, large and small,

would benefit from the trust because the establishing funds would be invested to yield an estimated return of at least $20 million annually which could then fund programs to meet unmet needs.

For example, these programs could be used

to provide health insurance to the underinsured and uninsured, to fund money-strapped mental health initiatives, and address the root causes of drug

abuse and violence.

This significant amount of financial resources would be directed by local people for the benefit of our community. I have personally experienced how a small organization like START can provide long-term benefits to individuals and neighborhoods. The charitable trust concept resonates with my experience and values. The amount under discussion can, I firmly believe, contribute significantly to our city for generations to come.

Therefore, I urge that the proposed conversion and merger with WellPoint be given careful consideration. It will preserve CareFirst as a strong corporate player in our region, serving customers, supporting our literacy program and other worthy causes for many, many years, in providing new resources to our community that will address our most pressing needs.

Thank you.

COMMISSIONER MIREL: Thank you very much, Mr. Duffles.

The next witness is Stan Rich. Is Mr. Rich here?

Okay, then, we will move to the next witness, Evanna Powell. Good evening, Ms. Powell.

STATEMENT OF EVANNA POWELL

MS. POWELL: Good evening. I am Evanna Powell, a citizen and taxpayer of the District of Columbia. I am here to express my position regarding the conversion and acquisition of CareFirst Blue Cross-Blue Shield by WellPoint Health Networks, Inc.

The District of Columbia is in the midst of a health care crisis, and the sale of CareFirst Blue Cross-Blue Shield, a nonprofit insurance provider, to WellPoint Health Networks, Inc., a for-profit insurance provider, will make the health care crisis worse for the District of Columbia government, the District of Columbia taxpayers, and the District of Columbia's citizens in need of coverage currently provided by CareFirst Blue Cross-Blue Shield.

On April the 30th, 2001, the District of

Columbia privatized its public health care delivery system by signing a nine-year to $1 billion maximum contract with Doctors Community Health Care Corporation in Greater Southeast Hospital. The delivery of some of the contract services has been questioned by the D.C. Council, the independent auditing firm, patients and nonpatient citizens.

In September of 2000, the George Washington University Health Plan announced plans to cease operation in February of 2000 and, to my knowledge, it has ceased operation.

In March of 2000, Med-Link Hospital, formerly Capital Hill Hospital, filed a Chapter 11 bankruptcy proceeding which allows a hospital to reorganize and pay creditors or cease operation.

On May 10th, 2002, Columbia Hospital for Women, a 36-year-old hospital, closed its doors.

CareFirst Blue Cross-Blue Shield is one of the insurance providers that was available for enrollees of the defunct George Washington Health plan. At the time George Washington enrollees were seeking other health plans to join, CareFirst

premiums were higher than George Washington's premiums. At the time the George Washington plan premiums were as low as $134.74 a month. Under CareFirst, the premiums of a typical 45-year-old single District resident would have been $204 to $249 a month. The deductible, $500. And the reimbursement for covered services, 80 percent.

The average health care premiums in the area are predicted to rise 12 to 18 percent. The premiums for CareFirst are predicted to increase 13 to 15 percent this year. Those increases at the 15 percent rate would equal $30 to $36, for total premiums of $234 to $285 a month. Those increases are surely to discourage citizens from seeking other insurance coverage. Those increases are surely to add more citizens to the number unable to access health care services.

Not only does the District need to vote against the conversion and acquisition of CareFirst by WellPoint, the District also needs to construct a new state-of-the-art, full-service, fully-funded public hospital on the current site of D.C.

General, where District residents can use their insurance and can know they will receive medical services.

At this time, backed-up and closed emergency rooms are delayed and offer no medical service because the District has no public hospital. A possible biological, nuclear and chemical terrorist attack, all District residents, workers and visitors need insurance coverage and access to medical treatment. The request for conversion and acquisition of CareFirst with the $234 to $285 per month premiums will result in more District residents being without insurance coverage and, more importantly, being without access to medical treatment.

In closing, I ask that you not approve the conversion and acquisition. Thank you.

COMMISSIONER MIREL: Thank you very much, Ms. Powell. And thank all of you for being so concise in your presentations. That really makes the operation go much more smoothly.

The next witness is Vanessa Dixon. Is

Vanessa Dixon here?

If not, we will move on to George Barker. Mr. Barker.

STATEMENT OF GEORGE BARKER

MR. BARKER: Thank you. My name is George Barker, B-a-r-k-e-r. I am speaking on behalf of the Health Systems Agency of Northern Virginia, a private nonprofit entity that is a regional health planning agency for the Northern Virginia area. I thank you for the opportunity to comment at this forum.

CareFirst sells policies in Northern Virginia as well as in the District of Columbia and Maryland and Delaware. There are 200,000 Virginians who are insured by CareFirst. Their fate will be decided by you, the District of Columbia insurance commissioner. The Virginia Commissioner of Insurance has determined that because the District has comparable oversight provisions as Virginia for the conversion and sale of CareFirst to WellPoint, and because the GHMSI plan is domiciled in the District, Virginia defers

responsibility for insurance commissioner approval or denial of the transaction to the District. The Virginia attorney general, however, has certain responsibilities for this proposal, including the disposition of charitable assets.

It is incumbent, therefore, for you, the District of Columbia insurance commissioner, to state that the interests of all those covered by GHMSI, including Virginians, will be equally and fully considered in the decision.

As Virginians, there are several things that we bring to the consideration of this proposal. First among them is the people of Northern Virginia. Some have the perception of Northern Virginia as affluent and relatively homogenous. We are, however, very diverse. Our minority population has been growing rapidly and exceeds 35 percent, with the minority population almost equally divided among Latinos, African Americans and Asian Americans.

Although median incomes are high and unemployment is low, there are many who have modest

incomes. Northern Virginians with modest incomes often are uninsured. A survey done during the winter of 2000-2001, just before there were major signs of economic slowdown and well before September 11, found that 11 percent of Northern Virginians lack any health care coverage. With a population approaching two million just from the District line through Prince William and Loudon counties, there are more than 200,000 Northern Virginians who are uninsured. This is as many as are enrolled in CareFirst.

Although we cannot quantify it at this point, it is almost certain that the number of Northern Virginians who are uninsured has increased in the past year and a half.

The Northern Virginians most likely to be uninsured are those who are ethnic minorities. Surveys have shown that almost half of Latinos and about a quarter of Asian Americans in Northern Virginia are uninsured. Those just happen to be the fastest growing parts of the Northern Virginia population.

African Americans and non-Hispanic whites are much less likely to be uninsured, with lack of insurance only slightly higher among African Americans and among non-Hispanic whites in Northern Virginia.

An important factor in this decision is the Virginia law which requires nonprofit insurers such as CareFirst to make health insurance available to certain types of persons. For-profit insurers, such as WellPoint, do not have the same requirement. Approval of this proposal, therefore, could negatively affect access to medical insurance at a time when lack of insurance coverage is a major concern in Northern Virginia.

The Northern Virginia market historically has been competitive and balanced, with a variety of health insurance options. There are five insurers, each with 200 to 250,000 covered lives in Northern Virginia. All other plans combined have about the same number.

The five major carriers provide a good variety of models. Two are nonprofit. One,

CareFirst, is a Blue Cross plan, and another is a former Blue Cross plan that converted to for-profit status. Only one, Aetna, has been a major nationwide carrier. Another, Kaiser Permanente, is a traditional health maintenance organization. And the other, MAMSI, is a regional for-profit managed care plan.

There are benefits to having a diversity of choices that now exist, a diversity that would be diminished by the CareFirst-WellPoint proposal.

We in Virginia also can bring to the table experience with conversion of a Blue Cross plan from not-for-profit to for-profit. Trigon, which formerly was Blue Cross-Blue Shield of Virginia, is the largest insurer in the rest of Virginia and has a share of the Northern Virginia market as well. The perception of that insurer has evolved since its conversion from the gentle giant to not-so-gentle giant. Whereas providers and others found Blue Cross-Blue Shield of Virginia imposing and sometimes not the easiest to deal with, they were seen as approachable. That no longer is the case.

Just last week, for example, Trigon publicly announced, with substantial media coverage, that it would no longer have a contract with Carillion, the major hospital and health care entity in Roanoke, and much of Southwest Virginia. That situation may be resolved, but it demonstrates the difficult hard-ball approach now being applied.

Northern Virginia also has experience with other conversions, including at least two entities that went from not-for-profit to for-profit and back to nonprofit. Those experiences were illuminating. In both cases, there were major concerns with the operations while for-profit that dissipated after becoming nonprofit again. One was the former Group Health Association HMO that was sold to Humana and then to Kaiser. Kaiser provides not only greater opportunity for insurance coverage but also many community services, including coverage to moderate income families that have been uninsured. Those public benefits did not exist while Humana operated the plan.

After more than a half century as a

nonprofit, Arlington Hospital embarked on a for-profit joint venture with Hospital Corporation of America, then known as Columbia HCA, in the latter part of the 1990s.

Reston Hospital Center was part of the joint operation. During the period that the two hospitals were operated jointly as for-profit entities, the following changes occurred at Arlington:

One, charity care decreased.

Two, the percent of Arlington Medicaid patients served went down, served by Arlington Hospital went down, with more Arlington Medicaid patients going outside the county, principally to Alexandria and Fairfax Hospitals to receive care.

And three, charges increased substantially at a rate much greater than the regional average. Arlington Hospital decided after a couple of years to go back to being a nonprofit hospital, and Reston remained controlled by HCA. Since then Arlington's charity care and Medicaid services have returned to historical levels, and charges actually

went down one year.

In 2000, just over 3 percent of all care provided at Arlington Hospital was charity care for persons below the poverty line. In the same year the comparable charity care level at Reston Hospital Center, Arlington's former partner, was 0.35 percent. Just over one-tenth the level at Arlington and far below any other hospital in Northern Virginia.

This difference in charity care rates is particularly striking because the immediate service areas of the two hospitals have many similarities, with income diversity and substantial minority populations. Many low and moderate income and uninsured individuals in Reston and Herndon have to end up going elsewhere to get their care, principally to the Inova hospitals.

Although we are not taking a position on the CareFirst-WellPoint proposal until we have more information, the experiences that we have had in Northern Virginia cause us concern with the proposed change from nonprofit to for-profit

status.

Absent a mechanism for guaranteeing that there are not similar negative effects that would follow this proposal, we have doubts about whether the conversion and sale should be approved.

We also look forward to more information on whether such a conversion and sale is essential to the survival of CareFirst. We have serious questions about whether CareFirst, with its dominant position in Maryland, recently listed as sixth in the country, and competitive situation in the District and Virginia, would be unable to survive without this proposal. If it cannot survive, would not the same apply to Kaiser and MAMSI?

Unless there is compelling evidence that CareFirst cannot survive without this deal, this proposal should be approved only if it is determined to be in the public interest. That case, at least to date, has not been made.

The interests of the residents and CareFirst enrollees in Virginia as well as those in

the District, demand that approval be granted only if there is clear and convincing evidence that the CareFirst-WellPoint proposal would be a public benefit.

Thank you for considering our comments and perspective.

COMMISSIONER MIREL: Thank you very much, Mr. Barker. And let me just say that I am mindful of my responsibility to the people of Northern Virginia who are involved in this as well, and I pledge to you that I will give them the same consideration and concern that I will for the people of the District of Columbia.

The next witness is James Whitley.

STATEMENT OF JAMES WHITLEY

MR. WHITLEY: Good evening. Thank you for allowing me to speak tonight. My name is James Whitley. That's W-h-i-t-l-e-y. I am a staff attorney with Community Catalyst, and we are a Boston-based national advocacy organization that promotes health care justice.

The primary goal of Community Catalyst is to strengthen the voice and involvement of consumers and communities wherever decisions shaping the future of their health care systems are being made.

Our team of attorneys, health policy analysts and education specialists provides a range of technical assistance services that includes policy analysis, legal assistance, strategic planning, and community organizing support.

We have worked over the past seven years in over 35 States in our ongoing effort to ensure that the conversion of health insurers and hospitals to for-profit status serves the public interest.

We continue to use our national vantagepoint and multi-state experience to assist State and local organizations as well as regulators and legislators whose health care institutions are undergoing conversion.

Toward these goals, we have communicated with and assisted numerous community groups in the

District of Columbia as they review the proposed conversion by CareFirst. We share the community's significant concerns regarding the proposed conversion of CareFirst, and what effect it will have on the access to health care in the District and D.C. residents.

These concerns point to the need for the most thorough review process before any decision can be made on CareFirst's application.

The task then for the District regulators, as it always is for regulators in every State, is how to review the application as rigorously as possible so as to ensure that the decision is made only after fully factoring in the impact the conversion will have on the residents of D.C. and how the local health care system will be forced to adjust after the change.

This will require a through investigation into the health impact indicators, in addition to the usual considerations of the financial valuation and allowing for public participation and feedback.

Only by considering all of these factors

will a thorough review of the conversion proposal happen. I want to just discuss those two factors that I mentioned, participation of the public and the health impact study.

Given that those with the most at stake in the proposed conversion are the District's health consumers and the community members whose nonprofit health insurer would drastically change in focus and operation post-conversion, structuring a review process that not only allows for public comment but also seriously values and considers the participation of the larger D.C. community, is crucial.

While traditionally many similar conversion transactions have not included the voice and opinions of the community, it is only through an incorporation of the public sentiment that regulators can fully determine what would be in the public interest. Any review process that does not provide for the gathering of public comment and the inclusion of the community throughout is obviously woefully inadequate, and the decision issuing from

such a process could only be incomplete.

This type of public forum creates one of many possible opportunities for that essential community involvement. The insurance commissioner is urged to structure other such opportunities for the public's voice to be heard in this review. And in my written statement I have given a couple of suggestions which I won't go into now.

A health impact study is equally necessary to thoroughly and rigorously review the proposed conversion. Such a study should consider the data related to D.C. consumers' current access to health care and then project forward to determine the likely impact the proposed conversion of the District's nonprofit health insurer would have on access, were it approved.

Relevant factors in such an inquiry might include but need not be limited to indicators of health needs in the District, access to care in the District, and projected changes to those data.

Only armed with the results of such a study can any regulator determine if a conversion

proposal would be prejudicial and hazardous to the public affected.

A recent example where the importance of the health impact study to the review process was understood fully comes from Kansas, where the insurance commissioner, Kathleen Sibelius, earlier this year disapproved a conversion proposal applied for by Blue Cross and Blue Shield of Kansas to demutualize and merge with Anthem Insurance Companies.

Commissioner Sibelius relied on health-related data to do a forward-looking analysis of the likely health impact the conversion would have on the Kansas public.

Similar to the law of D.C., Kansas' conversion law prohibits the insurance commissioner from approving a conversion if it would be prejudicial or hazardous to the public.

If these terms are to have any meaning, they must be operationalized; in other words, working definitions must be identified as to what would constitute prejudicial or hazardous outcomes

for the public.

Any review process which doesn't operationalize such crucial terms would be seriously lacking and could not accurately indicate what would be in the public interest.

In the Kansas example, Commissioner Sibelius analyzed the health impact data gathered by independent analysts and by her own Kansas insurance department testimonial team. She concluded that the conversion would be both prejudicial and hazardous to Kansas residents since premium rates would have to be increased dramatically to achieve the express profit goals of the insurer post-conversion, and she therefore disapproved the conversion.

This and other lessons learned through our experiences and other States clearly proved that a complete and rigorous review of a conversion proposal must include a thoughtful consideration of relevant health impact data and opportunities for open public participation in the process.

Community Catalyst urges the Insurance

Commissioner Mirel and the residents of the District to undertake such a rigorous review and consider the CareFirst conversion proposal very carefully.

Thank you.

COMMISSIONER MIREL: Thank you, Mr. Whitley. We will read your entire statement. Did you come today from Boston for this?

MR. WHITLEY: I sure did.

COMMISSIONER MIREL: I thank you very much for that. We are truly grateful to have you here.

Okay. The next witness is someone who is not on the schedule but who should have been, and that is Dr. Howard Smith. I am going to call him now. Is he here? Yes. It is our error that he was left off. So we will allow him to speak now.

STATEMENT OF DR. HOWARD SMITH

DR. SMITH: Thank you. I thought I was going to be last.

My name is Howard Smith. That's S-m-i-t-h. And I am a physician in the District of Columbia. My practice is obstetrics and

gynecology. I speak for myself and I speak on behalf of my patients.

Today's paradigm for health care in the United States is managed care. It arose as a consequence of self-regulation in a marketplace dominated by for-profit insurance companies. As a consequence of this changing domain, even not-for-profit insurance companies embraced this paradigm in order to survive. Public opinion polls show that 85 percent of all insured Americans are satisfied with managed care. Some would say that the minority of physicians who questioned managed care as the new paradigm is just crying sour grapes. While they were benefiting from fee-for-service medicine, others with a different vision of the future were making change.

However, these changes were not being made out of disdain for what was valued in America's health care system. Rather, they were being made to preserve them. These were honorable men and women. Patients, Americans and citizens must listen and learn about the need for change in

health care.

I didn't come here to praise an old paradigm, I came here to bury it. The faults of an old paradigm live on, while the good is often forgotten. So let it be with the paradigm of not-for-profit insurance. The visionaries who replaced it believe that because of it physicians, ambitious and thirsty for wealth and power, abused and exploited health insurance companies. If that were so, it was a grievous fault, and I could understand their reasons for wanting change. After all, they are all honorable people whose only ambition is the best interest of America.

In deference to the old paradigm, however, the vast majority of physicians were still motivated by higher ideals. Tens of thousands of jobs were created. An entirely new biomedical industry was developed, and millions who were sick and injured were returned to health and productivity.

Proponents of the for-profit insurance would say that while the old paradigm of fee-for-service,

which was the product of a not-for-profit insurance industry, was exploited by ambitious practitioners, their paradigm provided health insurance for 84 percent of the population. It produced the best medical care in the world, and most importantly, it halted the accelerated growth of health care costs in America. Costs that would bankrupt the country.

Fees are the strengths professed by our luminaries in health care, all honorable people. Although these are true, it is also true that despite spending more on health care than any other nation on earth, $1.3 trillion a year, the numbers of uninsured are increasing. The World Health Organization ranks America's health care system a very mediocre 37th in the world, and the cost of health insurance has been increasing by more than 10 percent a year over the past several years, and that trend has no foreseeable end.

I speak not to disabuse anyone of these beliefs because, indeed, physicians were ambitious. After all, it was the ambition of an American

physician, Justin Ford Kimball, that actually laid the foundation of Blue Cross-Blue Shield in 1929. Yes, Americans were ambitious. Even before managed care, 24 times they were presented the kingly crown of the Nobel Prize, and 24 times they used that award not to enrich themselves but to further medical research. Such was their ambition.

I would do those proponents of for-profit insurance wrong if I accused them of selfishly coveting these achievements.
This certainly wasn't so. They exploited them to the maximum. These were honorable people who, unlike physicians, had nothing to gain; not fame, nor wealth, nor power.

The old paradigm is dead, and with it died the ambition that they feared. Nevertheless, in a matter of speaking, the old paradigm left a will. This testament can be found in the words of the Hippocratic oath. This legacy transcends all the paradigms and health care systems that ever were and will ever be. It would be wrong of me to indict those who brought about managed care of

demanding anything less from physicians. I would never do this, nor would I impeach them for developing a system that seduces physicians to behave in a way that betrays this legacy, if that were not the case.

After all, they are all honorable people. Yet our time of health care would discharge people from hospitals before they are medically ready to leave. It would limit the numbers of office visits patients could have with doctors. It would force patients to remain within a given network of preferred providers rather than to seek out physicians who they prefer. It would interrupt the usual collegial relationships between providers. It will interfere in the patient-doctor relationship. It would disregard the health of those who suffer from mental illness. It would change physicians into providers and patients into insured lives. It would deny the medical necessity of treatment. It would disallow the prescription of needed medication if it determines they weren't cost-effective. It would cause 44 million people

to be uninsured. It would force people who need extended care facilities into abject poverty. It would deny prescription benefits to the elderly who most need it. It would downsize the Nation's health care system to a point of causing shortages, even under normal conditions. It would cause providers to place their relationships with health plans above those with patients. It would close public hospitals that traditionally would care for the poor and the uninsured. It would lead to America's pathetic ranking of 37th in the world. It would cause health insurance costs to increase at a faster rate than inflation.

These and many more are the consequences of policies tolerated as cost-cutting by those who crafted managed care. However, 8:46 in the morning on the 11th of September changed America as certainly as the Ides of March changed Rome, and these cuts became the bleeding wounds in the body of health care through which the daggers of 1500 different health plans, mostly for-profit, were thrust.

Each wound is a betrayal, and each wound bears its own unique signature. There is United Health Care and Aetna and Cygna, Health Net, WellPoint, Blue Cross-Blue Shield, Prudential.

Need I go on?

But the final blow wasn't thrust by a health plan; rather, it came from those who were most trusted; people like you, our policymakers. Although all honorable people, they supported these and many other cost-cutting measures by a largely for-profit insurance industry while they turned their backs on our health care system as its vital capacity was slowly and silently degraded by it.

Then came September 11th. Never once did they consider the effects of a downgraded health care system on a nation at war with terrorists. Never once. We were told that their paradigm of managed care didn't consider medical conditions arising from acts of war, covered benefits. For all practical purposes, as of 8:46 a.m. on the 11th of September, 2001, we all became uninsured. Because of their indulgence of special interests,

health care now lies on the steps of the Capitol, as did Caesar on the steps of the forum.

Of all the wounds inflicted in our health care system, this is the unkindest cut of all.

Rather than offering a solution, tonight we debate the merger between WellPoint and CareFirst. A merger that makes a solution even more elusive.

Now you could understand and feel a dent of pity for those who for-profit insurance left behind, the uninsured, because you, too, are among them. But let me not stir you to outrage nor harden your suspicion about the ambitions of those who caused this to happen because they always professed good intentions and denied profiting from their ambition, gaining nothing; not fame, nor wealth, nor power. I'm sure that each today are reflecting on this problem. After all, they are wise and honorable people. Only they know what made them ignore this defect in the paradigm of managed care, and no doubt it is they who will also be required to have answers.

It is not for me alone to raise your

indignation or to challenge their motives for I am only one doctor, a plain, blunt man. I have never the wit nor the words to cause others to express their wrath or to bring about change. I only say what now you yourselves should know: Change is necessary, but because of the changes in our world, this change that we debate tonight will prove to be gratuitous and costly.

The bleeding wounds in our health care system speak more eloquently for what is necessary than do I. They alone should move you.

Thank you.

COMMISSIONER MIREL: Dr. Smith, thank you very much. We appreciate the Shakespearean references and the way you put them together. And thank you for your testimony.

The next witness is Michael Preston. Welcome, Mr. Preston.

STATEMENT OF MICHAEL PRESTON

MR. PRESTON: Thank you, Commissioner Mirel, and I appreciate the opportunity to be here. I am Mike Preston. I am executive director of Med-Chi, the

Maryland State Medical Society. My organization represents approximately 6500 physicians across the State of Maryland, and we appreciate the opportunity to share with you tonight some of the perspectives and concerns that we have brought to bear on this issue within the State of Maryland, of course, where we believe that some of them have resounded quite loudly within policymakers and encourage you to take consideration of them as well.

Med-Chi, the Maryland State Medical Society, believes firmly in CareFirst as a not-for-profit, locally-based, independent organization, and the key distinction is not-for-profit, and locally-based is also great. But to be a not-for-profit organization is the starting point of our discussion, which is to say that the difference between a not-for-profit and a for-profit, we believe, fundamentally involves the mission. And the mission of a not-for-profit organization involves an element of community service, whereas a for-profit organization's fundamental mission is

one of creating value for its stockholders, and they are very different things, but of course they both have to be businesses and they both have to thrive, and they both have to be able to thrive successfully.

We believe that CareFirst, of course, needs to be able to thrive. We wouldn't be here and we wouldn't be opposed to this deal if we felt that CareFirst could not thrive as an independent, locally-based not-for-profit organization.

We have not seen evidence that it is unable to thrive as a not-for-profit, locally-based organization who, as a not-for-profit organization, must balance business imperatives with its community service mission and, indeed, must generate a surplus or, if you will, a profit. But the purpose of that surplus or profit is to pursue its community mission, not to enrich private interests, who are stockholders.

So it is with that perspective that we have analyzed this proposal, and harken back actually to a prior transaction involving GHMSI and

the conversion and the consolidation of CareFirst and the GHMSI about four years ago. And we were supportive of that transaction because we believe it advanced the notion of CareFirst as a stronger, locally-based, regional not-for-profit organization, and we sought a pledge from CareFirst management that it was not, that that transaction at that time was not a step toward a conversion to a for-profit status, which we opposed at that time and continue to oppose.

In fact, CareFirst management, in a letter from Mr. Jews to my organization, at that time pledged that the consolidation of CareFirst and GHMSI was not a step toward conversion, and that the organization's management had no intention to convert to a for-profit status. But here we are, only a few years later, facing precisely that proposal to convert and to be sold to an out-of-town organization.

We believe we have not seen any evidence that there is any compelling reason to support this transaction, conversion or sale.

The main arguments that the management has offered us are that they need access to capital, and they need to grow to compete. For what purpose do they need access to capital? We have heard references to a need to enhance their information technology infrastructure. And we have heard the argument that in general, they need capital because they need to grow to compete.

You have already heard references to the concerns that we share, which are that, well, why exactly do they need to grow to compete when they have a dominant share in large parts of this market, and why do they need access to outside Wall Street capital when in fact they have been successful in generating capital internally, from their operations generating a surplus upwards of $800 million over the last eight years?

And, indeed, coming from a time when they were near distress. The management deserves to be commended for its ability to do that. We would say very much on doctors' backs in many respects by virtue of the discounting phenomenon that has been

part and parcel of managed care, but nevertheless the company was successful in generating surplus, and that surplus represents, in effect, profit that the company, we believe, should be investing in its community service mission as a thriving local enterprise.

We believe there are major risks to this proposal, and would frame them in the context of how the company has sought to assure us that there aren't such risks. One of them is now that the company will remain a locally-based organization. They have pledged that its operations in Owings Mills and here in the District will remain and in effect that there will be no large scale cutting of employees, or pogrom of employees, to save money to generate return to justify this transaction.

They haven't actually pledged not to squeeze harder on the reimbursement to doctors, but we would submit that that is not a major concern because we don't believe that WellPoint as a buyer could squeeze the reimbursement to doctors significantly without wrecking its physician

network, and the evidence of that is its recent experience with its new Blue Choice network, in which they have had trouble in many cases filling out a network with substantial discounts.

So we believe that doctors are at the bottom and they are not significantly going to be able to squeeze doctors very hard. As a result we believe that if they are not going to get savings from cost-cutting of employees, and they are not going to be able to squeeze doctors very hard, how are they going to get money to pay stockholders to justify this transaction? It's going to have to come from some place. We submit that it's either going to come from hospitals and further destabilize the hospital economy in the District, which is unregulated, and destabilize the hospital economy in Maryland by undermining their all-payer system in Maryland, which they have pledged they are not going to do.

So having pledged that they are not going to undermine the all-payer system, we believe they cannot squeeze doctors very hard, and having

pledged that they are not going to cut employees substantially in their operations, where is the money going to come from to pay stockholders?

That leaves really only one place, we submit, and that is subscribers. It's going to mean higher premiums or lesser benefits, but the money has to come from some place to justify the transaction, whether it's a billion three or three billion eight. whatever the price is, that money has to come from some place to justify the stockholders that they should pursue it. And we believe that it will come from some place; that one of the propositions they have asserted to assure us that there are no risks to the transactions simply can't be true, one or more. Either there will be cost-cutting and employee operations will disappear substantially in local facilities; that they will undermine the all-payer system in Maryland and destabilize hospitals further in the District; that they will work to destabilize and further reduce physician prices. We think they will try, but we think unsuccessfully because we think doctors are

already at the bottom.

And money will have to come from some place, so we think it will also come from subscribers, all of which adds up to no good justification for the proposal, we believe. And being supporters of a locally-based, not-for-profit organization, and one that we believe can thrive as such, we are opposed to the deal and encourage you to look at the proposal in that light.

Thank you very much.

COMMISSIONER MIREL: Thank you, Mr. Preston. Thank you for coming over from Maryland to give us the benefit of your thoughts.

Mr. McGarrah.

STATEMENT OF ROBERT E. McGARRAH, JR.

MR. McGARRAH: Commissioner Mirel, on behalf of President Josh Williams and the 150,000 members of the Metropolitan Washington Council of the AFL-CIO, I want to thank you for the opportunity to appear before you on one of the most important health insurance concerns in Washington, D.C. and the Nation, making health care for the

people a higher priority than profits for insurance companies.

Working families are struggling every day to come up with the money they need for health insurance. Wages here in the District of Columbia are expected to increase less than 3.5 percent this year, yet CareFirst right now is asking for an additional premium increase of 13 to 15 percent.

Where will the money come from when union families have never seen their incomes go up 13 to 15 percent a year?

These rate hikes mean one thing: More D.C. working families will go without the health care they need because they can't afford to pay more. Yet as hard as things are now, it is absolutely clear that if you approve WellPoint's takeover of CareFirst, even more D.C. residents will suffer. Why? Because there will be even less money for health care. WellPoint is a for-profit company. It has an established record of taking 12 percent more than CareFirst out of every premium dollar for its top priority: Wall Street analysts

and shareholders.

WellPoint CEO, Leonard Schaefer, laments Wall Street's demands for quarterly earnings, but it hasn't stopped him from extracting record profits from health care. Nor has it stopped him from opposing patients' rights at every single turn, all the way up to United States Supreme Court, and the case I have is cited here.

In fact, if you approve this CareFirst takeover, D.C. residents will be victimized by a company that specializes in gimmicks and deception. What WellPoint calls consumer choice, leading public health experts call Enroning health insurance, leaving patients with no insurance, while promising them health security.

Harvard's Professor Katharine Swartz describes WellPoint's scheme this way:

"Instead of shifting more of the initial costs of medical care onto policyholders, they are shifting the risk of higher costs onto policyholders. WellPoint Health Networks and other for-profit insurance companies are among the

carriers that have designed these new policies. In the case of an individual employee, the policies typically cover most costs of medical care, often including drugs, up to $2000 or $3000. However, then the employee has to pay all the costs incurred in the so-called corridor between $2000 or $3000 limit and a cap, perhaps $5000. Above the cap the insurer pays all the costs. The initial $2000 or $3000 of covered medical expenses is an allowance that an employer provides each employee to spend on medical care below the $5000 or higher cap, which is the real deductible for the policy. An employee could opt to reduce the allowance in the event that it were having financial problems, say a recession might occur, and the employee would then be at risk for more of the medical expenses below the cap."

Commissioner Mirel, just consider what this kind of scheme would mean for working families here in D.C. Take a woman who five months into pregnancy is told that you have a high-risk pregnancy; or imagine a 55-year-old man diagnosed with prostate cancer. You, the patient, rather

than the insurer, are suddenly bearing the risk of medical expenses that fall within the corridor of uncovered costs. This isn't health insurance. This is the same sort of rip-off that happened at Enron. It's an illusion of health security perpetrated by a for-profit company which is eager, first of all, to please Wall Street. D.C. residents deserve much better.

As if WellPoint's Enron-style health insurance weren't enough, WellPoint is now under a Federal criminal investigation by the United States Attorney's Office in Boston for its relationship with TAP Pharmaceuticals. Wall Street analysts have recently downgraded WellPoint's stock and, according to Dow Jones news wires, TAP Pharmaceuticals agreed in 2001 to pay $875 million to resolve criminal charges and civil liabilities related to alleged fraudulent drug pricing and marketing for Lupron, a prostate cancer drug.

There are over 71,000 D.C. citizens who have no health insurance at all right now. Why? Because profit-hungry insurance companies refuse to

sell them a decent, affordable health plan.

The problem is even worse in WellPoint's home state of California, where 6,371,000 uninsured Californians have no health insurance whatsoever, and WellPoint has been operating there for some time, as you know.

The last thing we need here in Washington, D.C. is another for-profit health insurance monopoly. As the biggest health insurance company in D.C. and Maryland, CareFirst would become just another subsidiary of a huge California company. What little accountability and control we have over CareFirst would be gone forever.

What CareFirst needs is to get back to basics, selling decent, affordable health insurance to every D.C. resident who needs it.

Commissioner Mirel, you have a golden opportunity to make decent, affordable health care a reality. You can prevent thousands of D.C. residents from losing their health insurance by opposing this CareFirst conversion and merger. You can set CareFirst on the right path to do that job

by reforming it, rather than allowing it to become a for-profit WellPoint subsidiary. You can bring it back to basics, selling health insurance that works for all the people, not another Enron-style product that nobody needs.

Thank you.

COMMISSIONER MIREL: Thank you very much, Mr. McGarrah.

I am going to go back now to some of the people who were not here when I called their names, and if they are present now, please come forward and make your presentation.

First, Dr. Judy Okkema. Is she here?

Secondly, Stan Rich. Is he here?

And third, Vanessa Dixon. Is Ms. Dixon here?

Okay. We have some time, and I will be glad at this point to recognize anyone who would like to say something who was not on our list, as I promised I would, if we were finished before 9 o'clock. Is there anybody else who would like to make a statement?

If not, I would like to thank all of you for your very thoughtful and careful and well-put-together testimony. I really think that this was an extremely useful forum, and I thank all of you who participated. We will take to heart everything you said, and this will become part of the record of the case.

Thank you, and good evening.

[Whereupon, at 7:45 p.m., the proceeding was adjourned.]